PROFFITT EYE CENTER

711 N. Custer Ave.
Grand Island, NE 68803
308.382.1781 • 800.352.3083
Fax: 308.382.1474

Authorization to Disclose and Obtain Information

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

PATIENT: ______________________ ____________ ________________

Patient Name SS# Date of Birth (MM/DD/YY)

____

Address City State Zip

MY AUTHORIZATION **I authorize the following using or disclosing party:**

____

Organization or Individual **Phone and/or Fax Number**

____

Address **City** **State** **Zip**

to use or disclose the following health information.

☐ All of my health information

☐ My health information relating to the following treatment or condition:
____

☐ My health information covering the period of healthcare from (date) ____________ to (date)____________

☐ Other:____

The above party may disclose this health information to the following recipient:

Name (or title) and organization____

Address ____

City ________________________________State ____________Zip__________

Phone _______________Fax _______________Email_______________

REASON FOR DISCLOSURE: **The purpose of this authorization is (check all that apply):**

☐ At my request

☐ Other: ____

☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

<u>This authorization ends:</u>

☐ On (date)______________

☐ When the following event occurs:_______________________________________

MY RIGHTS: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ___________________________________ Date: ___________________

If the patient is a minor or unable to sign please complete the following:

☐ Patient is a minor: ____________ years of age

☐ Patient is unable to sign because: ____

Signature of Authorized Representative: ____

Date: _________________

Print Name of Authorized Representative: ____

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other: _________________________

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS: This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ___________________________________

Date: ___________________ Time: ______________________

ADDITIONAL CONSENT FOR HIV/AIDS: This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ___________________________________

Date:___________________ Time: ______________________